

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005110</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/08/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>COMMUNITY WESTVIEW HOSPITAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3630 GUION RD</b> <b>INDIANAPOLIS, IN 46222</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of 1 (one) State hospital complaint.</p> <p>Complaint: #IN00094634 Unsubstantiated; lack of sufficient evidence.</p> <p>Facility: #005110</p> <p>Date: 3-8-2012</p> <p>Surveyor: Karilyn M. Tretter, RN Public Health Nurse Surveyor</p> <p>Westview Hospital is in compliance with 410 IAC 15-1.5-6, Nursing services and 410 IAC 15-1.6.7, Respiratory care services, Indiana State Hospital Licensure Rules.</p> <p>QA: cloughlin 04/30/12</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE